RESPECT-Mil

Re-Engineering Systems of Primary Care Treatment in the Military

Defense Centers of Excellence for Psychological Health & TBI

Office of The Surgeon General, Army

Deployment Health Clinical Center

Uniformed Services University

3CM®

SAVANNAH, GA 14-16 JUNE 2010

RESPECT-Mil Central

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Overview

- ★ Why Primary Care?
- ★ What is RESPECT-Mil?
- ★ RESPECT-Mil Implementation
- ★ Innovations in the Pipeline
- ★ Road Ahead

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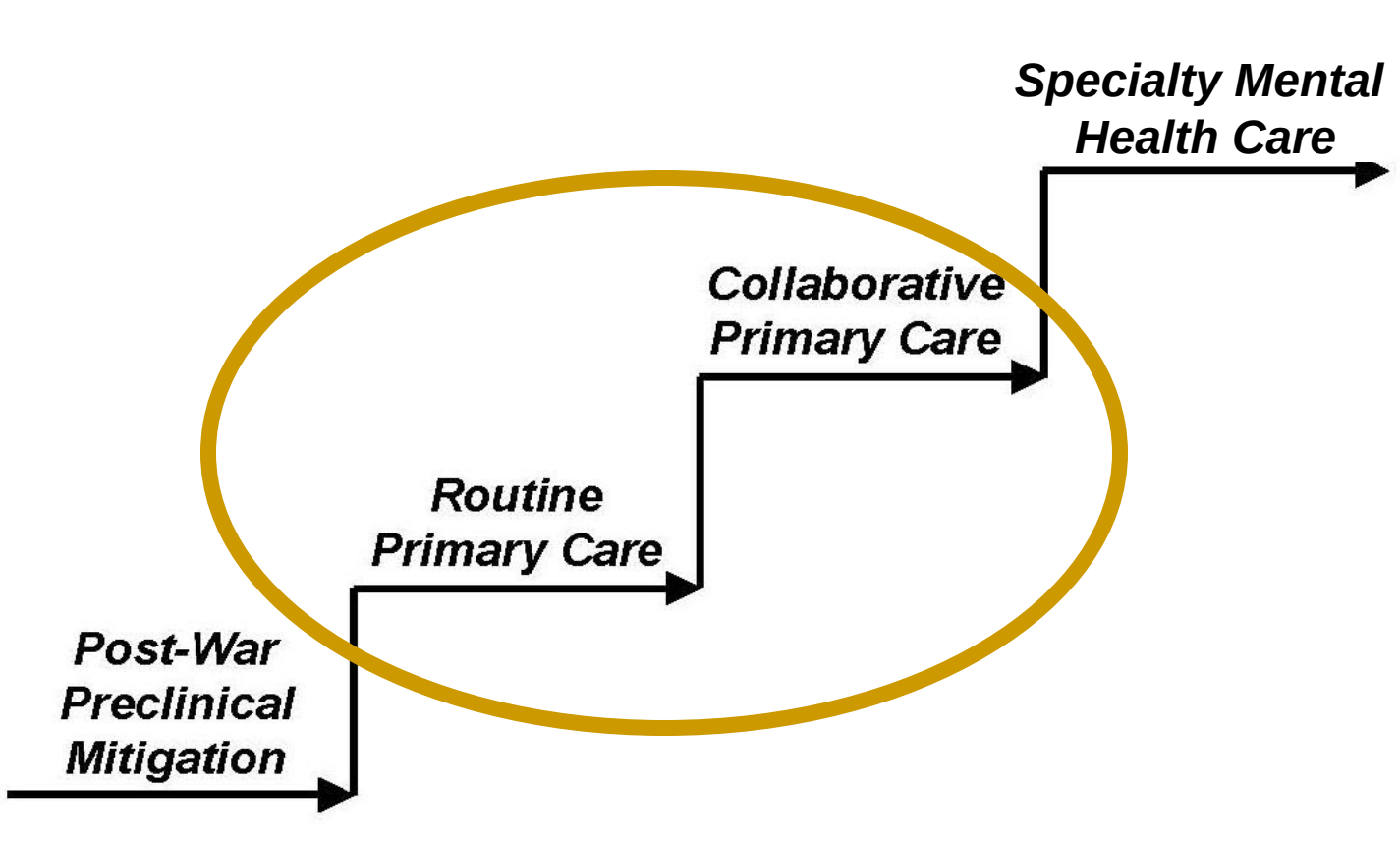
Primary Care
The Fulcrum for Deployment Health Services



Engel et al, 2004, Can We Prevent A Second Gulf War Syndrome? Advances in Psychosomatic Medicine

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Why Primary Care?
Mental disorders & the Iraq War

	BROAD* before-after	STRICT* before-after
Depression	11%- 15%	5% - 8%
Anxiety	16%- 18%	6% - 8%
PTSD	9%- 18%	5% - 13%
Any of these	21%- 28%	9% - 17%

Hoge, et al. N Engl J Med. 2004;351:13-22.

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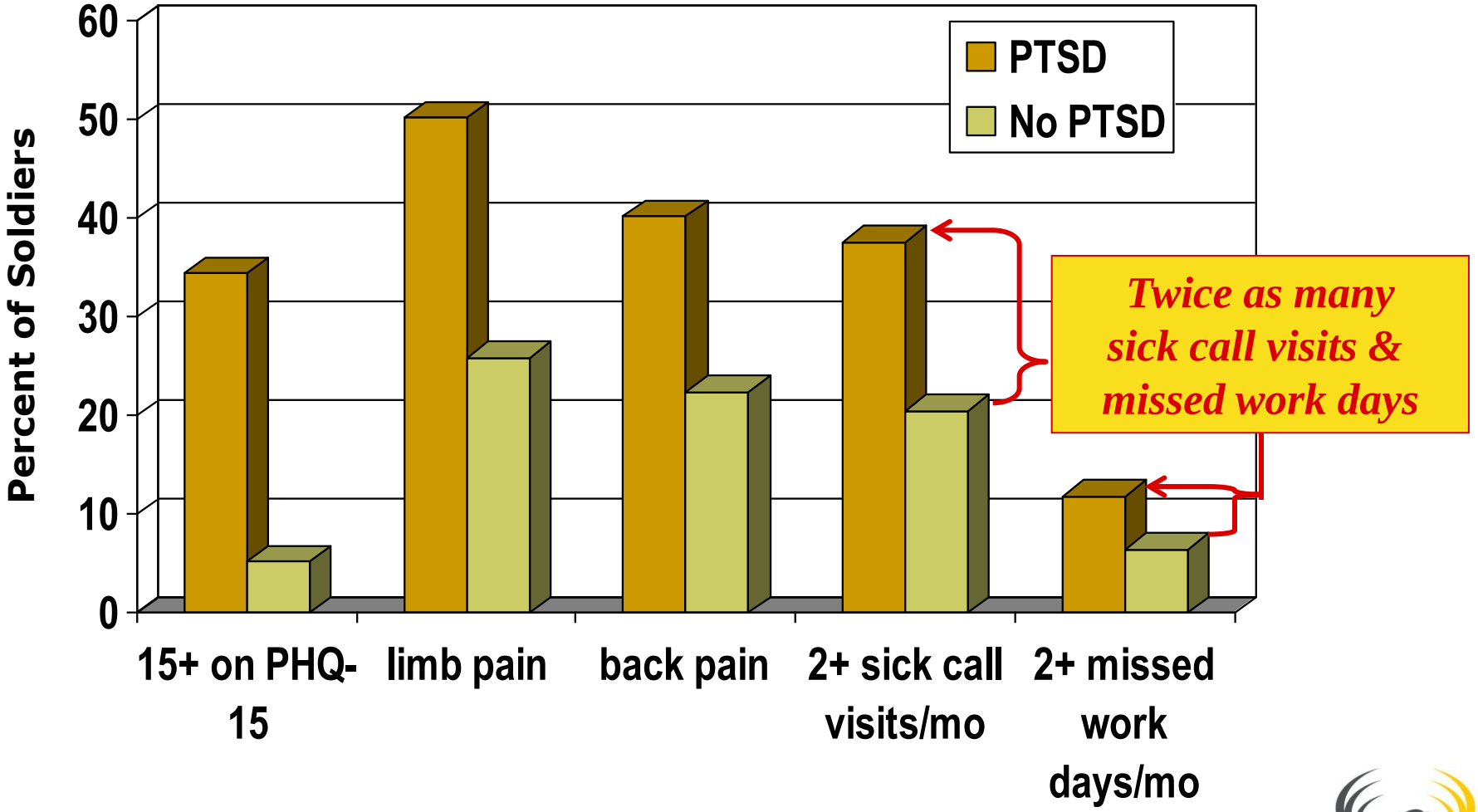
Potential for Offset: Service Use & Missed Work

2,863 Iraq War returnees one-year post-deployment



Hoge et al, Am J Psychiatr, 2007

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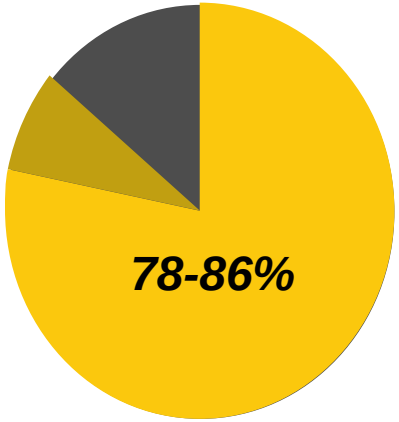
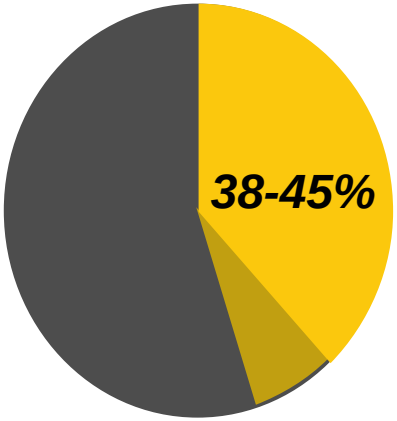
Why Primary Care?
A Gap Between Needs & Services

Got help (past 12 months)

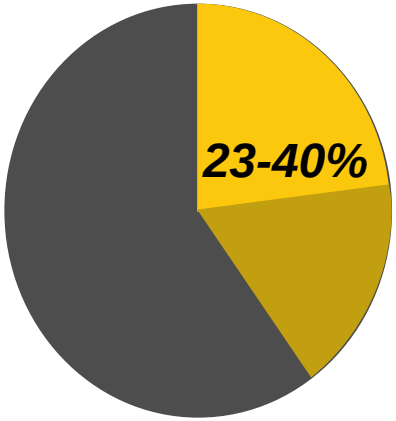
Acknowledge a problem



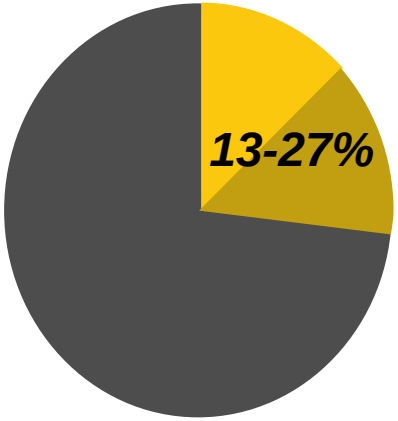
Want help



Any professional



Mental health professional



Hoge CW, et al. N Engl J Med. 2004;351:13-22.

RAND "Invisible Wounds Study" (Tanielian et al, 2008)

Half receiving mental health services received less than minimally adequate care

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Post-Deployment Service Delivery Challenges

Post-Deployment Health Assessments

10% of screens are PTSD positive

(Hoge et al, JAMA, 2006;295:1023-1032)

22% of those who are PTSD screen positive receive referrals to a specialist

(GAO, 2006)

48-56% of those referred for positive screens are seen by specialist

(Hoge et al, JAMA, 2006;295:1023-1032)

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Primary Care…

Where Soldiers Get Their Care

- Mean primary care use is 3.4 visits per year
- 88-94% have one or more visits per year
- Primary care approach to mental health is an opportunity to…
  - Reduce stigma & barriers
  - Intervene early
  - Reduce unmet needs
  - Reduce unnecessary service use

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Primary Care Intervention is Evidence-Based

Randomized trials offer sound evidence that systems-level approaches benefit…

- ★ Depression (e.g., IMPACT Trial BMJ 2006)
- ★ Suicidal ideation & depression (Bruce et al, JAMA 2004)
- ★ Depression and physical illness (e.g., Lin et al, JAMA, 2003)
- ★ PTSD and physical injury (Zatzick, AGP, 2004)
- ★ Panic disorder (e.g., Roy-Byrne et al, AGP 2005)
- ★ Somatic symptoms (e.g., Smith et al, AGP 1995)
- ★ Health anxiety (e.g., Barsky et al, JAMA 2004)
- ★ Substance dependence (e.g., O'Connor et al. Am J Med. 1998)
- ★ Dementia (e.g., Callahan et al, JAMA 2006)

RESPECT-Depression

British Medical Journal, September 2004

Re-engineering systems for the treatment of depression in primary care: cluster randomised controlled trial

Allen J Dietrich, Thomas E Oxman, John W Williams Jr, Herbert C Schulberg, Martha L Bruce, Pamela W Lee, Sheila Barry, Patrick J Raue, Jean J Lefever, Moonseong Heo, Kathryn Rost, Kurt Kroenke, Martha Gerrity, Paul A Nutting

THE MACARTHUR INITIATIVE ON *depression* & Primary Care AT DARTMOUTH & DUKE

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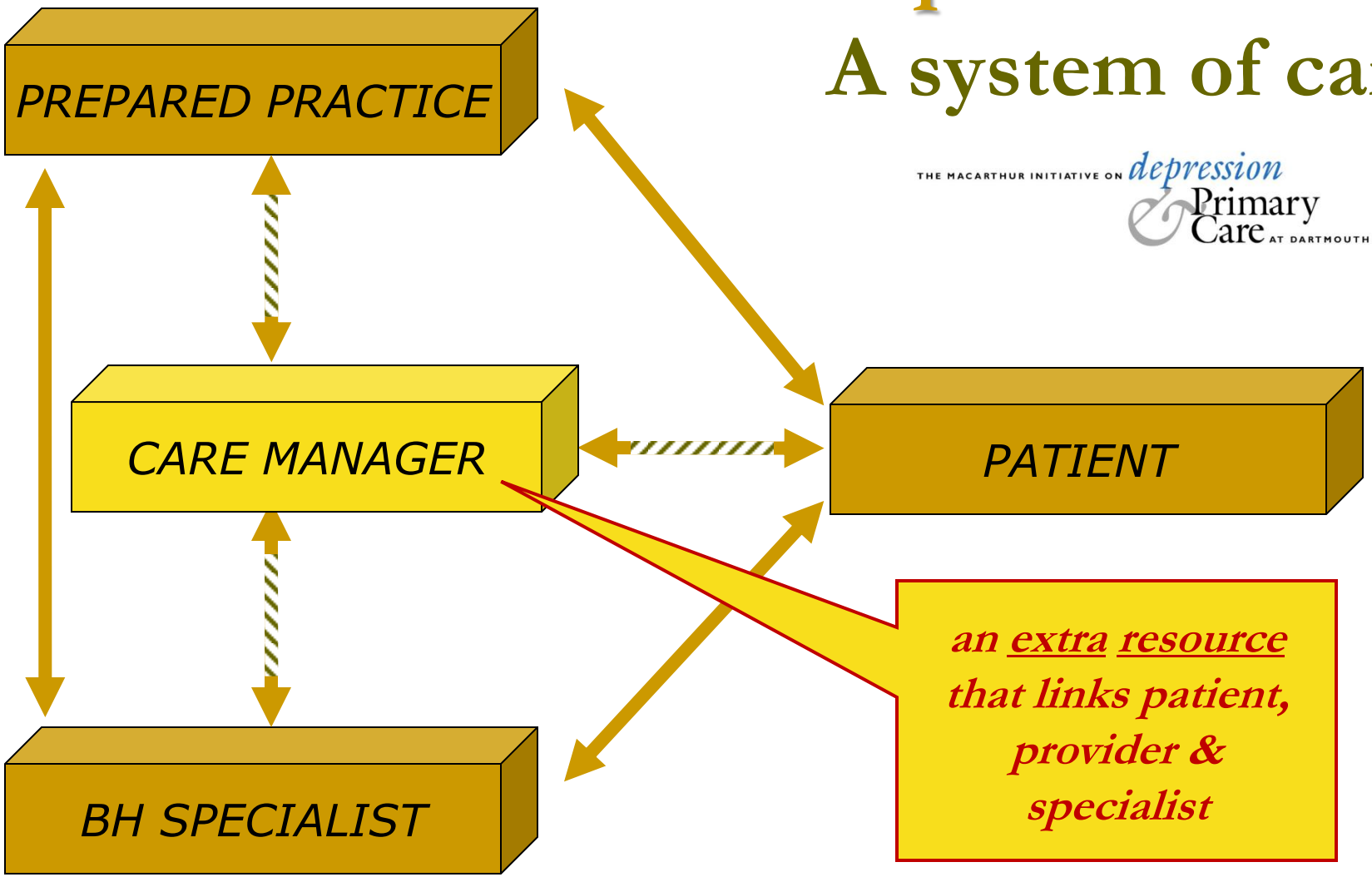
3 Component Model

A system of care



THE MACARTHUR INITIATIVE ON depression & Primary Care AT DARTMOUTH & DUKE

Oxman et al, Psychosomatics, 2002;43:441-450

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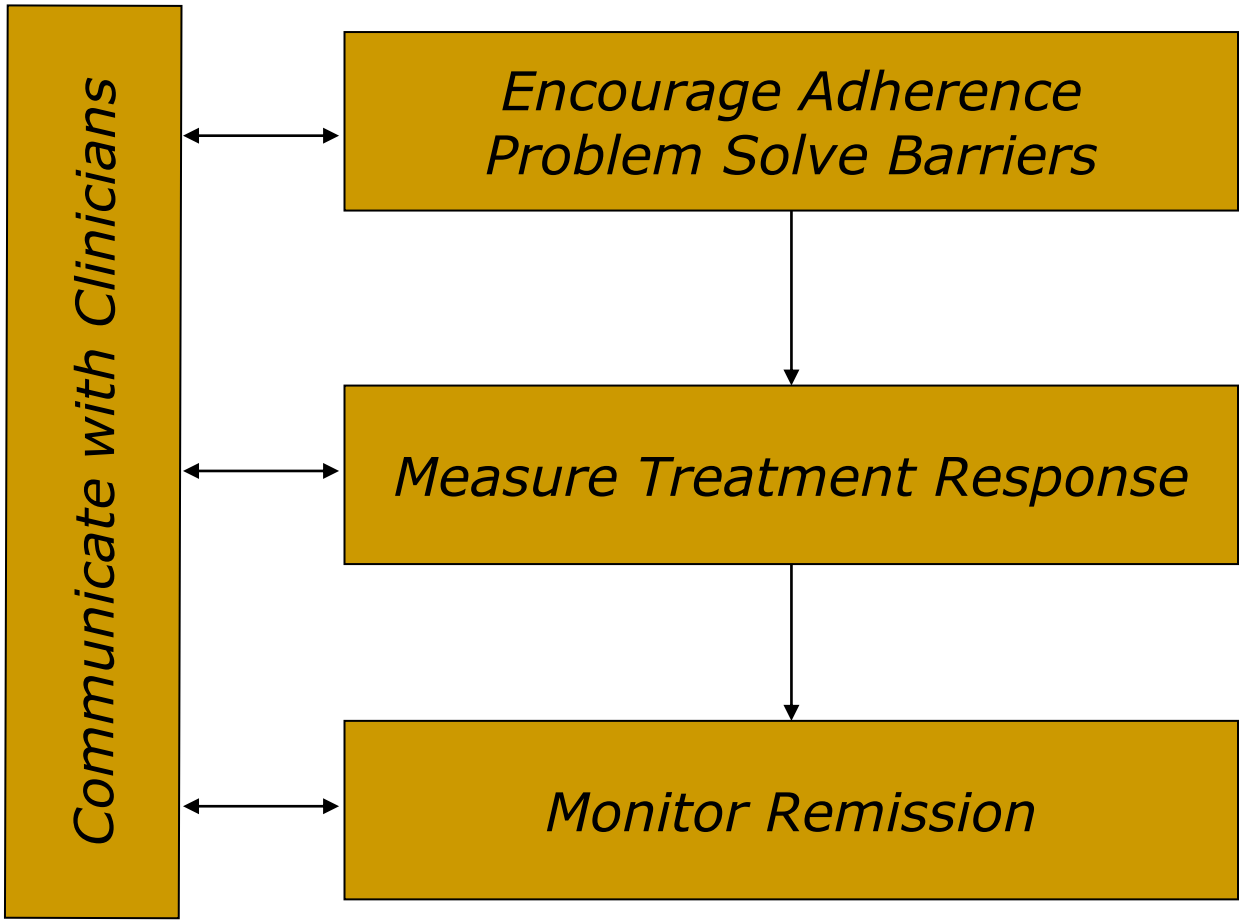
Care Facilitator Functions



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More Than "Pill Pushing"

Potential to Improve…

- ★ Detection
- ★ Monitoring
- ★ Providers' treatment choices
- ★ Patients' adherence to treatment
- ★ Timely treatment adjustment
- ★ Continuity of care

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Feasibility Study in 2005-06 – Robinson TMC

MILITARY MEDICINE, 173, 10:935, 2008

RESPECT-Mil: Feasibility of a Systems-Level Collaborative Care Approach to Depression and Post-Traumatic Stress Disorder in Military Primary Care

COL Charles C. Engel, MC USA; Thomas Oxman, MD†; MAJ Christopher Yamamoto, MC USA‡; MAJ Darin Gould, MC USA§; Sheila Barry, BA¶; Patrice Stewart, PhD‖; COL Kurt Kroenke, MC USA (Ret.)#; John W. Williams, Jr., MD**; Allen J. Dietrich, MD††*

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Dissemination Sites

OPORD 07-34 – 42 clinics at 15 sites

Phase I sites

- ★ *Fort Drum, NY*
- ★ *Fort Bragg, NC*
- ★ *Fort Campbell, KY*
- ★ *Fort Hood, TX*
- ★ *Fort Stewart, GA*

Phase II sites

- ★ *Fort Benning, GA*
- ★ *Fort Bliss, TX*
- ★ *Fort Polk, LA*
- ★ *Fort Riley, KS*
- ★ *Fort Carson, CO*

Phase III sites

- ★ *Fort Lewis, WA*
- ★ *Schofield Barracks, HI*
- ★ *Vilseck, GE*
- ★ *Schweinfurt, GE*
- ★ *Vicenza, IT*

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Expansion Sites

OPORD 10-25 – 53 clinics at 19 sites

Phase IV sites

- ★ *Bamberg, GE*
- ★ *Baumholder, GE*
- ★ *Katterbach, GE*
- ★ *Wiesbaden, GE*

Phase V sites

- ★ *Walter Reed, DC*
- ★ *Fort Eustis, VA*
- ★ *Fort Gordon, GA*
- ★ *Fort Jackson, SC*
- ★ *Fort Knox, KY*
- ★ *Fort Rucker, AL*
- ★ *West Point, NY*

Phase VI sites

- ★ *San Antonio TX*
- ★ *Fort Sill OK*
- ★ *Fort Leavenworth KS*
- ★ *Fort Leonard Wood MO*
- ★ *Fort Huachuca AZ*
- ★ *Fort Irwin CA*
- ★ *Fort Wainwright AK*
- ★ *Korea*

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RESPECT-Mil Implementation

Macro-level (Program-level) Approach

- RESPECT-Mil Implementation Team (R-MIT):
  - Monitors program implementation & fidelity
  - Trains & consults with site teams
  - Develops & disseminates education modules and tools
  - Pilots & evaluates new components
  - Performs site visits

- RESPECT-Mil Site Teams:
  - Primary Care Champion – Monitors local program & process
  - Behavioral Health Champion – Monitors facilitator caseloads
  - Facilitator - RN, 1 per 6K in eligible population
  - Administrative assistant - 1 per 10K in eligible population

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Micro-level (Clinic-level) Approach

- ★ Approach contained in "how to" guides
- ★ Primary care providers undergo 2 hours of Web-Based Training
- ★ Brief primary care PTSD & depression screening
- ★ Positive screen followed by diagnosis & severity assessment
- ★ Patient education materials
- ★ Primary care-based psychosocial options
- ★ Care Facilitator assistance option
- ★ Web-based care management support system
- ★ Accountable, continuous follow-up to remission
- ★ Weekly BH Specialist staffing

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Clinic Structure

- ★ **Approach contained in "how to" guides**
- ★ Primary care providers undergo 2 hours of Web-Based Training
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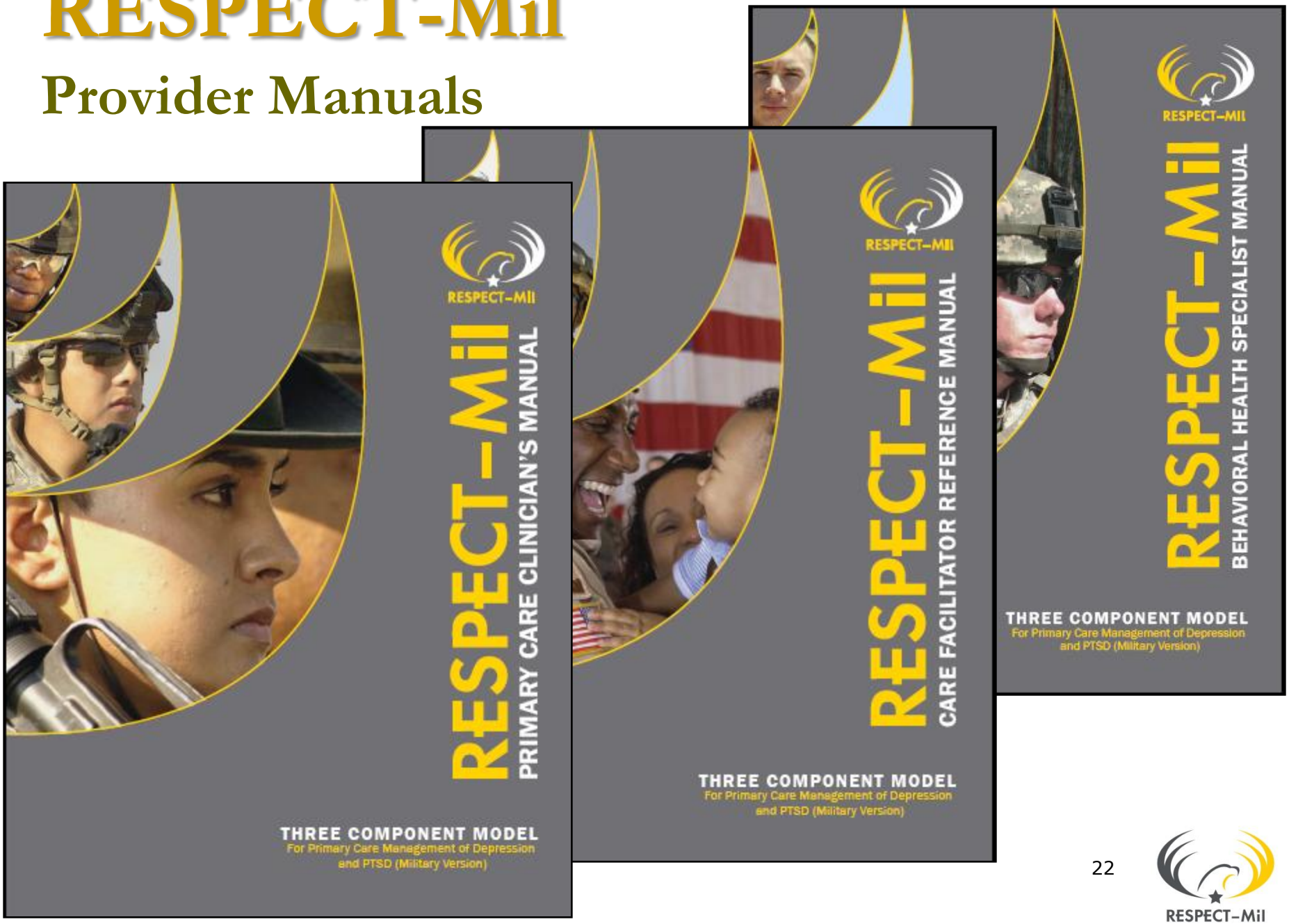
Provider Manuals



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Clinic Structure

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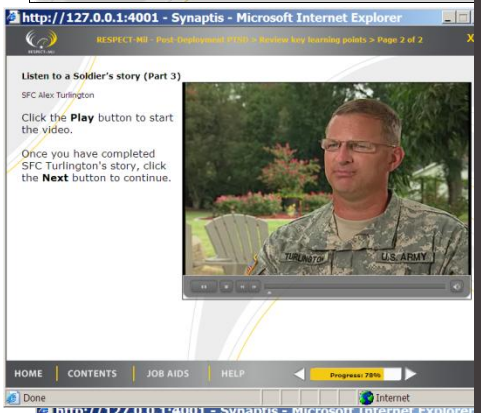
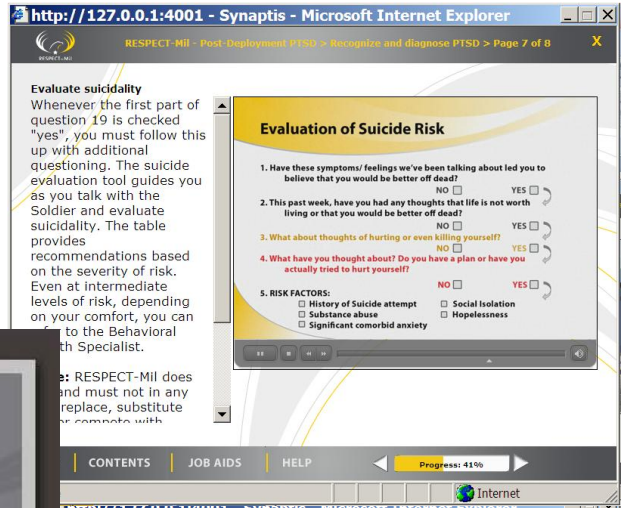
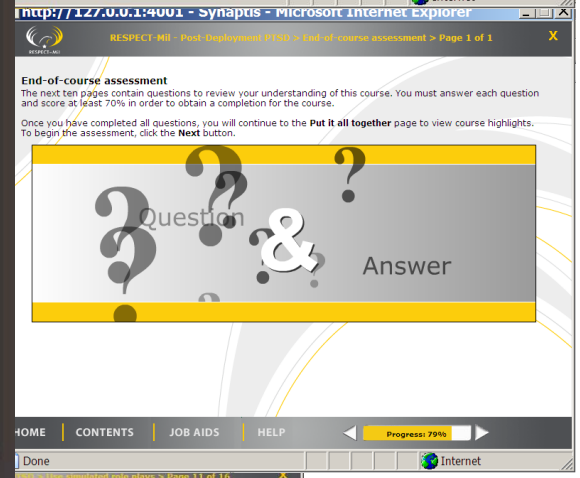
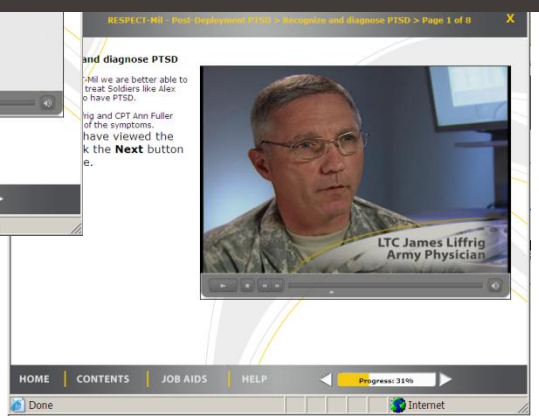
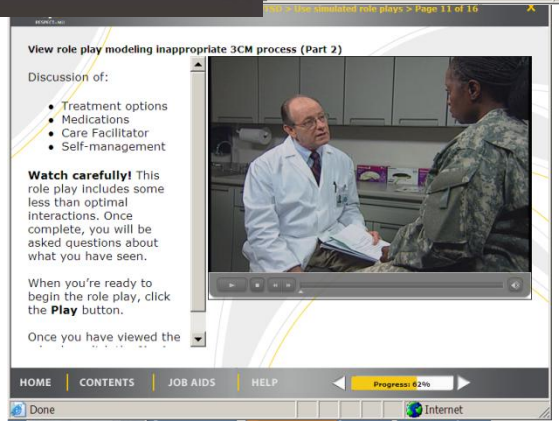
Web-Based PTSD & Depression Training for Primary Care Providers*











* *Includes suicide assessment training*

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Clinic Structure

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MEDICAL RECORD - RESPECT-Mil PRIMARY CARE SCREENING

For use of this form, see MEDCOM Circular 40-20; The Surgeon General is the proponent.

TODAY'S DATE: _____

The Army Surgeon General mandates that all Soldiers routinely receive the following primary health care screen.

Please check the best answer to each of the questions on this page. Enter your personal information at the bottom and return this page to the medic or nurse.

PATIENT HEALTH QUESTIONNAIRE

SECTION I *(Check all that apply):*

Over the LAST 2 WEEKS, have you been bothered by any of the following problems?

1. Feeling down, depressed, or hopeless. ☐ Yes ☐ No
2. Little interest or pleasure in doing things. ☐ Yes ☐ No

SECTION II *(Check all that apply):*

Have you had any experience that was so frightening, horrible, or upsetting that IN THE PAST MONTH, you...

3. Had any nightmares about it or thought about it when you did not want to? ☐ Yes ☐ No
4. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ☐ Yes ☐ No
5. Were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No
6. Felt numb or detached from others, activities, or your surroundings? ☐ Yes ☐ No

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PATIENT'S HEALTH QUESTIONNAIRE *(Additional Comments):*

Provider please reference section and question number when entering additional comments from patient. Please sign and date entry.

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Single Item PTSD Screen (SIPS) for Primary Care

Were you recently bothered by a past event in which you thought you'd be injured or killed?

Not Bothered / Bothered A Little / Bothered A Lot

Gore et al, 2008, General Hospital Psychiatry

Single Item PTSD Screen (SIPS) for Primary Care Generation 2

Think about the biggest threat to life you've **EVER** experienced or witnessed first-hand.

On a scale of 0 to 10, how much has this event bothered you **during the past month**? (0 is not bothered and 10 is extremely bothered)

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Clinic Structure

- ★ Approach contained in "how to" guides
- ★ Primary care providers undergo 2 hours of Web-Based Training
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PTSD Instrument (PCL-C)

PCL

Below is a list of problems and complaints that persons sometimes have in response to stressful life experiences. Please read each question carefully circle the number in the box which indicates how much you have been bothered by that problem *in the last month.* Please answer all 19 questions.

	No.	Response:	Not at all	A little bit	Moderately	Quite a bit	Extremely
ONE	1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	0	1	2	3	4
	2	Repeated, disturbing dreams of a stressful experience from the past?	0	1	2	3	4
	3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	0	1	2	3	4
	4	Feeling very upset when something reminded you of a stressful experience from the past?	0	1	2	3	4
	5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	0	1	2	3	4
THREE	6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	0	1	2	3	4
	7	Avoid activities or situations because they remind you of a stressful experience from the past?	0	1	2	3	4
	8	Trouble remembering important parts of a stressful experience from the past?	0	1	2	3	4
	9	Loss of interest in things that you used to enjoy?	0	1	2	3	4
	10	Feeling distant or cut off from other people?	0	1	2	3	4
	11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	0	1	2	3	4
	12	Feeling as if your future will somehow be cut short?	0	1	2	3	4
TWO	13	Trouble falling or staying asleep?	0	1	2	3	4
	14	Feeling irritable or having angry outbursts?	0	1	2	3	4
	15	Having difficulty concentrating?	0	1	2	3	4
	16	Being "super alert" or watchful on guard?	0	1	2	3	4
	17	Feeling jumpy or easily startled?	0	1	2	3	4
		For Primary Care Provider - Subtotal	0 +	+	+	+	+
			Total = _____				
	18	IF you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? _____Not difficult _____Somewhat difficult _____Very difficult _____Extremely difficult					
	19	During the last 2 weeks have you had thoughts that you would be better off dead, or of hurting yourself in some way? _____Yes _____ No If 'Yes', how often? ____Several days ____More than half the days ____Almost everyday					

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Clinic Structure

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Participant Education &Self-Management Materials

HOW CAN YOU IMPROVE YOUR SLEEP?

Sleep problems are common for those with PTSD. Changing your sleep pattern can take at least six to eight weeks.

Here are some areas where you may improve your sleep.

Avoid Caffeine: Caffeine is a stimulant found in items such as coffee, tea, soda, and chocolate, as well as in many over-the-counter medications. Those with insomnia are often sensitive to mild stimulants, and should avoid caffeine six to eight hours before bedtime. You may want to consider a trial period of avoiding caffeine altogether.

Avoid Nicotine: Some smokers claim smoking helps them to relax, but nicotine is actually a stimulant. Relaxing effects may occur when nicotine first enters the system, but as it builds up, it produces an effect similar to caffeine. Avoid smoking, dipping, or chewing tobacco before bedtime, and don't smoke to get yourself back to sleep.

Avoid Alcohol: Alcohol is a depressant. While it might help you fall asleep, as alcohol is metabolized, your sleep can become more disturbed and fragmented. Avoid alcohol after dinner, and limit its use to small or moderate quantities.

Cautiously Use Sleeping Pills: Sleep medications are effective only temporarily. If taken regularly, they lose effectiveness in about two to four weeks. Over time, sleeping pills may make sleep problems worse or lead to an insomnia "rebound." Many people, after long-term use of sleeping pills, mistakenly conclude that they need them to sleep

Participant Brochure

SELF-MANAGEMENT WORKSHEET

There are several things you can do to help yourself feel better, even when you're not at your best. Start by selecting one of the activities from this list. Remember to take it slowly at first and add new things as you begin to feel better.

1. Make time for pleasurable physical activities.

Be sure to make time to concentrate on your basic physical needs. One example is walking for a certain length of time each day.

For _____ days next week, I'll spend at least _____ minutes doing _____.

2. Find time for pleasurable activities.

Even though you may not feel as motivated or happy as you used to, commit to scheduling a fun activity (such as a favorite hobby) at least a few times a week.

For _____ days next week, I'll spend at least _____ minutes doing _____.
(Remember to make your goal both easy and reasonable.)

3. Spend time with people who can support you.

It's easy to avoid contact with people when you're feeling down. But, it's times like these that you need the support of friends and family. If you can, explain to them what you are experiencing. If you don't feel comfortable talking about it, that's all right. Just asking them to be with you, maybe during one an activity, is a good first step. (Suggestions include: meeting a friend for coffee, going shopping with a friend, playing cards or taking a walk with a neighbor, working with your spouse in the garden – anything that is social and enjoyable.)

During the next week, I'll make contact at least _____ times with _____ (name) doing/talking about: _____.

4. Practice Relaxing.

For many people, the changes that come with depression or PTSD can lead to anxiety. Since physical relaxation can lead to mental relaxation, practice relaxing in another way. Try deep breathing, taking a warm bath, or just finding a quiet, comfortable, peaceful place. Say comforting things to yourself like, "It's okay."

For _____ days next week, I'll practice physical relaxation at least _____ times, for at least _____ minutes each time. (Remember to make your goal both easy and reasonable.)

5. Simple goals and small steps.

It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others can't. It can be hard to deal with them when you're feeling sad, have little energy and aren't thinking as clearly as usual. Try breaking down large problems into smaller ones and then take one small step at a time. Give yourself credit for each step you accomplish.

The problem is: _____.
My goal is: _____.
Step 1: _____.
Step 2: _____.
Step 3: _____.

6. Eat nutritious, balanced meals.

You are what you eat. Many people find that when they eat more nutritious, balanced meals, they not only feel better physically, they feel better emotionally and mentally also.

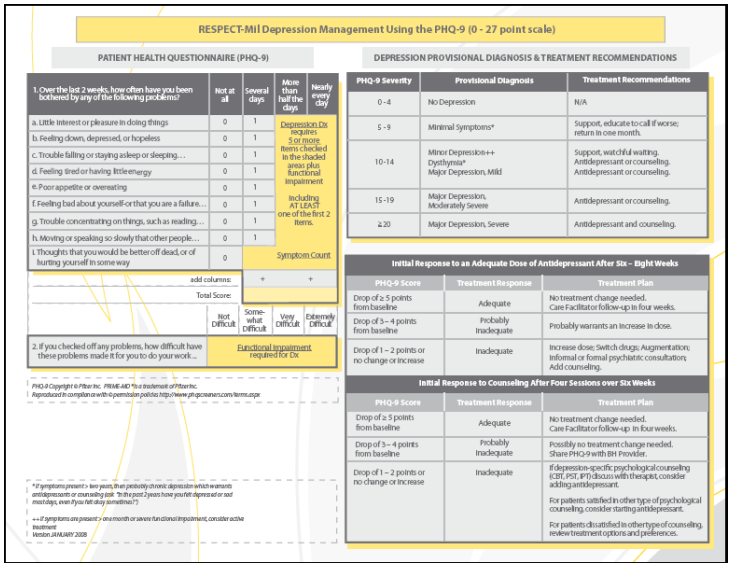
During the next week, I will improve my diet by: _____.
(Example: "Strive for five." Eat at least five fruits and vegetables a day.)

7. Avoid or minimize alcohol use.

Alcohol is a depressant and can add to feeling down and alone. It can also interfere with the help you may receive from antidepressant medication.

I will restrict my alcohol intake to no more than two drinks on no more than two days per week.

Goals & Self-Management Worksheet



RESPECT-Mil Depression Management Using the PHQ-9 (0 - 27 point scale)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1		
b. Feeling down, depressed, or hopeless	0	1		
c. Trouble falling or staying asleep or sleeping…	0	1		
d. Feeling tired or having little energy	0	1		
e. Poor appetite or overeating	0	1		
f. Feeling bad about yourself–or that you are a failure…	0	1		
g. Trouble concentrating on things, such as reading…	0	1		
h. Moving or speaking so slowly that other people…	0	1		
i. Thoughts that you would be better off dead, or of hurting yourself in some way	0			
add columns:			+	+
Total Score:				

Depression Dx requires 5 or more items checked in the shaded areas plus functional impairment

Including AT LEAST one of the first 2 items.

Symptom Count

2. If you checked off any problems, how difficult have these problems made it for you to do your work…	Not Difficult	Some-what difficult	Very difficult	Extremely Difficult

Functional impairment required for Dx

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* If symptoms present > two years, then probably chronic depression which warrants antidepressants or counseling (ask "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")

++ If symptoms are present > one month or severe functional impairment, consider active treatment

Version JANUARY 2008

DEPRESSION PROVISIONAL DIAGNOSIS & TREATMENT RECOMMENDATIONS

PHQ-9 Severity	Provisional Diagnosis	Treatment Recommendations
0 - 4	No Depression	N/A
5 - 9	Minimal Symptoms*	Support, educate to call if worse; return in one month.
10-14	Minor Depression++ Dysthymia* Major Depression, Mild	Support, watchful waiting, Antidepressant or counseling. Antidepressant or counseling.
15-19	Major Depression, Moderately Severe	Antidepressant or counseling.
≥ 20	Major Depression, Severe	Antidepressant and counseling.

Initial Response to an Adequate Dose of Antidepressant After Six – Eight Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3 – 4 points from baseline	Probably Inadequate	Probably warrants an increase in dose.
Drop of 1 – 2 points or no change or increase	Inadequate	Increase dose; Switch drugs; Augmentation; Informal or formal psychiatric consultation; Add counseling.

Initial Response to Counseling After Four Sessions over Six Weeks

PHQ-9 Score	Treatment Response	Treatment Plan
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Care Facilitator follow-up in four weeks.
Drop of 3 – 4 points from baseline	Probably Inadequate	Possibly no treatment change needed. Share PHQ-9 with BH Provider.
Drop of 1 – 2 points or no change or increase	Inadequate	If depression-specific psychological counseling (CBT, PST, IPT) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant. For patients dissatisfied in other type of counseling, review treatment options and preferences.

Provider "Fast Facts"

RESPECT-Mil

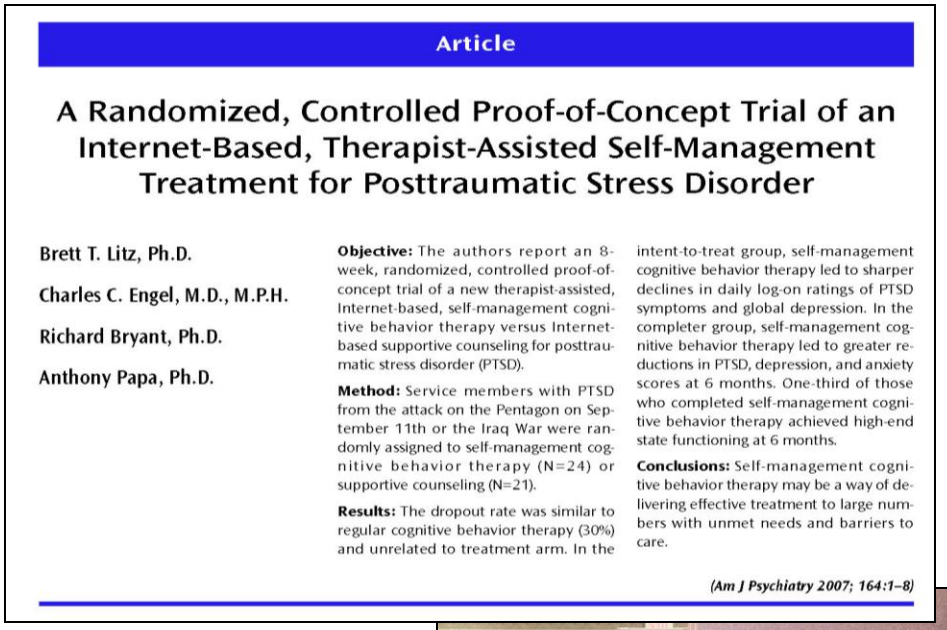
Clinic Structure

- ★ Approach contained in "how to" guides
- ★ Primary care providers undergo 2 hours of Web-Based Training
- ★ Brief primary care PTSD & depression screening
- ★ Positive screen followed by diagnosis & severity assessment
- ★ Patient education materials
- ★ **Primary care-based psychosocial options**
- ★ Care Facilitator assistance option
- ★ Web-based care management support system
- ★ Accountable, continuous follow-up to remission
- ★ Weekly BH Specialist staffing

RESPECT-Mil

DESTRESS-PC - Web-based, nurse assisted, PTSD self-training

Delivery of
Self-
TRaining &
Education for
Stressful
Situations –
Primary **C**are version



Article

A Randomized, Controlled Proof-of-Concept Trial of an Internet-Based, Therapist-Assisted Self-Management Treatment for Posttraumatic Stress Disorder

Brett T. Litz, Ph.D.
Charles C. Engel, M.D., M.P.H.
Richard Bryant, Ph.D.
Anthony Papa, Ph.D.

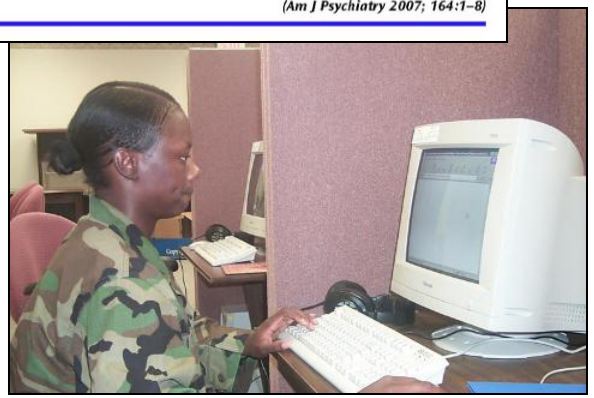
Objective: The authors report an 8-week, randomized, controlled proof-of-concept trial of a new therapist-assisted, Internet-based, self-management cognitive behavior therapy versus Internet-based supportive counseling for posttraumatic stress disorder (PTSD).

Method: Service members with PTSD from the attack on the Pentagon on September 11th or the Iraq War were randomly assigned to self-management cognitive behavior therapy (N=24) or supportive counseling (N=21).

Results: The dropout rate was similar to regular cognitive behavior therapy (30%) and unrelated to treatment arm. In the intent-to-treat group, self-management cognitive behavior therapy led to sharper declines in daily log-on ratings of PTSD symptoms and global depression. In the completer group, self-management cognitive behavior therapy led to greater reductions in PTSD, depression, and anxiety scores at 6 months. One-third of those who completed self-management cognitive behavior therapy achieved high-end state functioning at 6 months.

Conclusions: Self-management cognitive behavior therapy may be a way of delivering effective treatment to large numbers with unmet needs and barriers to care.

(Am J Psychiatry 2007; 164:1–8)



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Clinic Structure

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- ★ Primary care-based psychosocial options
- ★ **Care Facilitator assistance option**
- ★ **Web-based care management support system**
- ★ Accountable, continuous follow-up to remission
- ★ Weekly BH Specialist staffing

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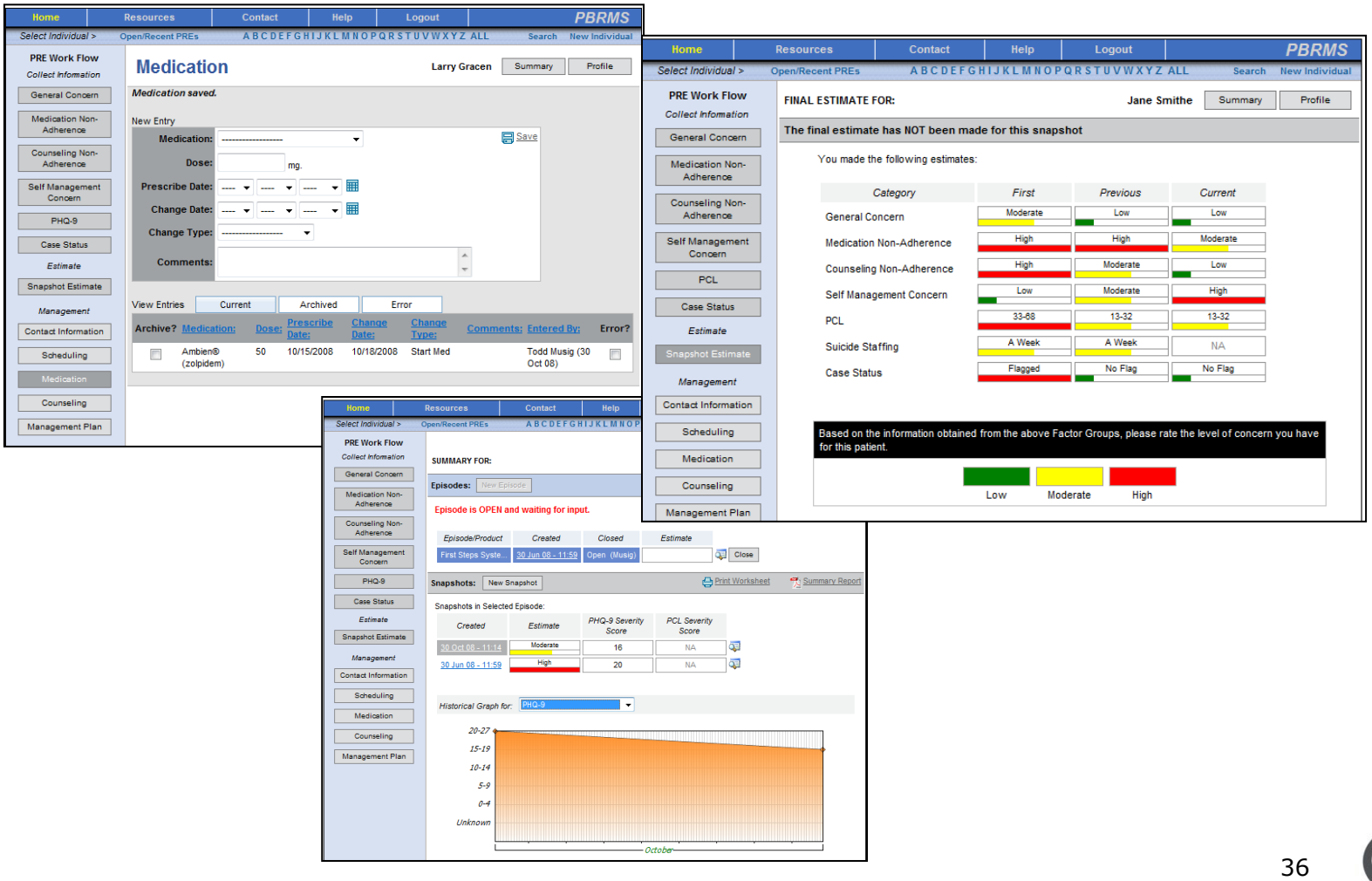
FIRST-STEPS – Web-based Care-Manager Support & Reporting System



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- ★ Web-based care management support system
- ★ **Accountable, continuous follow-up to remission**
- ★ **Weekly BH Specialist staffing**

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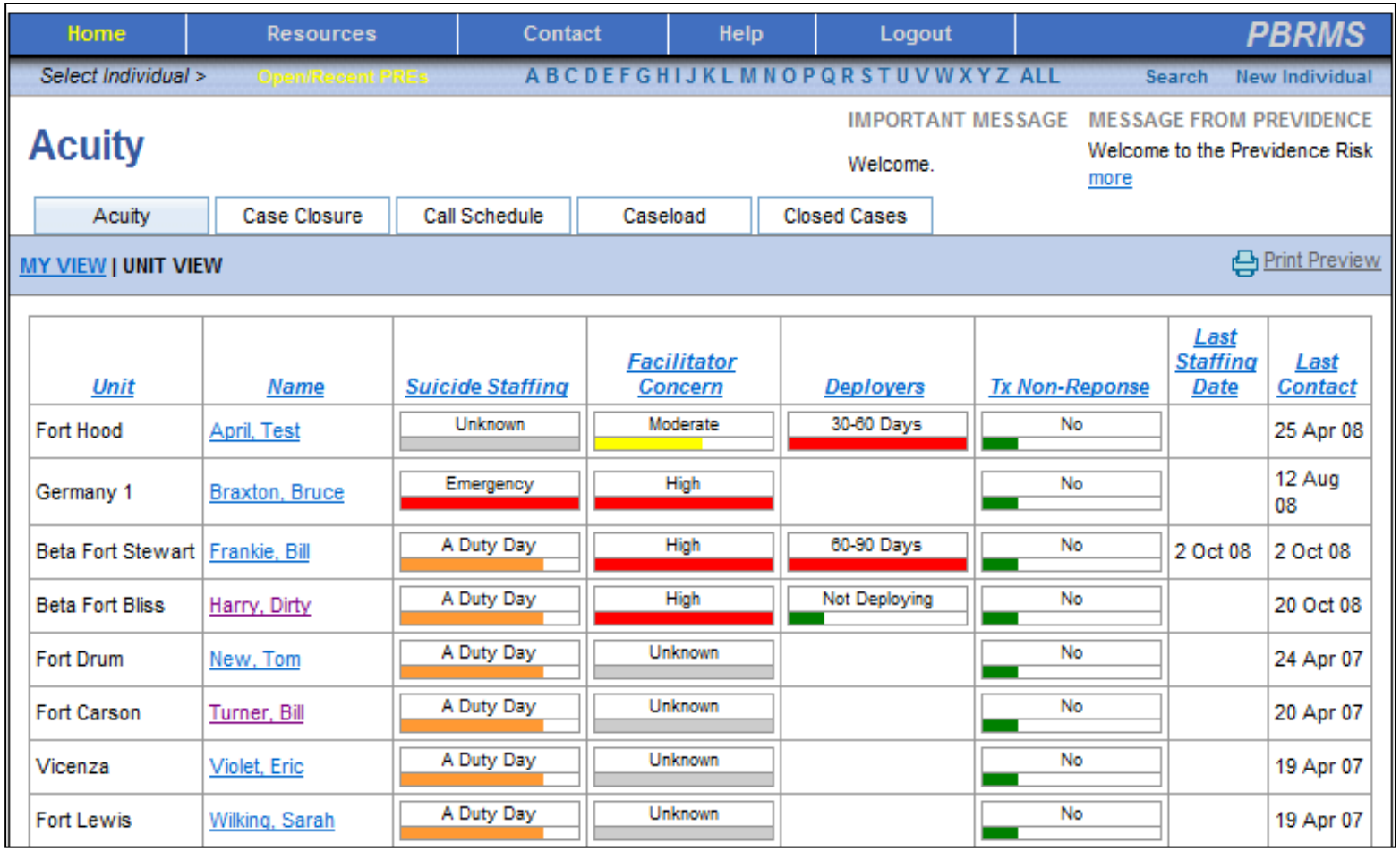
FIRST-STEPS – Improves Efficiency, Accountability & Effectiveness of Staffing



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Select Individual > Open/Recent PREs A B C D E F G H I J K L M N O P Q R S T U V W X Y Z ALL Search New Individual

Acuity

IMPORTANT MESSAGE
Welcome.

MESSAGE FROM PREVIDENCE
Welcome to the Previdence Risk more

Acuity | Case Closure | Call Schedule | Caseload | Closed Cases

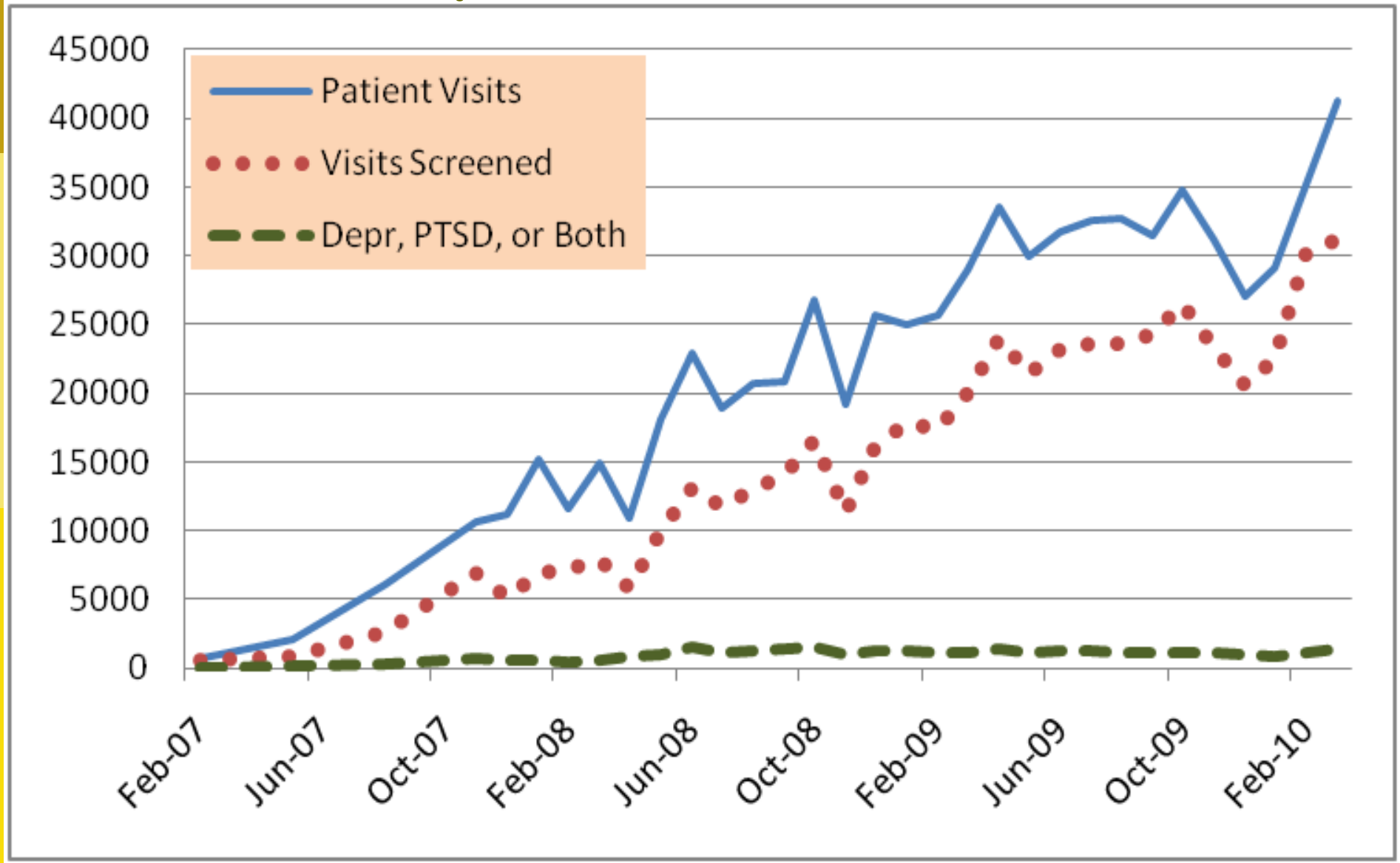
MY VIEW | UNIT VIEW — Print Preview

Unit	Name	Suicide Staffing	Facilitator Concern	Deployers	Tx Non-Reponse	Last Staffing Date	Last Contact
Fort Hood	April, Test	Unknown	Moderate	30-60 Days	No		25 Apr 08
Germany 1	Braxton, Bruce	Emergency	High		No		12 Aug 08
Beta Fort Stewart	Frankie, Bill	A Duty Day	High	60-90 Days	No	2 Oct 08	2 Oct 08
Beta Fort Bliss	Harry, Dirty	A Duty Day	High	Not Deploying	No		20 Oct 08
Fort Drum	New, Tom	A Duty Day	Unknown		No		24 Apr 07
Fort Carson	Turner, Bill	A Duty Day	Unknown		No		20 Apr 07
Vicenza	Violet, Eric	A Duty Day	Unknown		No		19 Apr 07
Fort Lewis	Wilking, Sarah	A Duty Day	Unknown		No		19 Apr 07

RESPECT-Mil

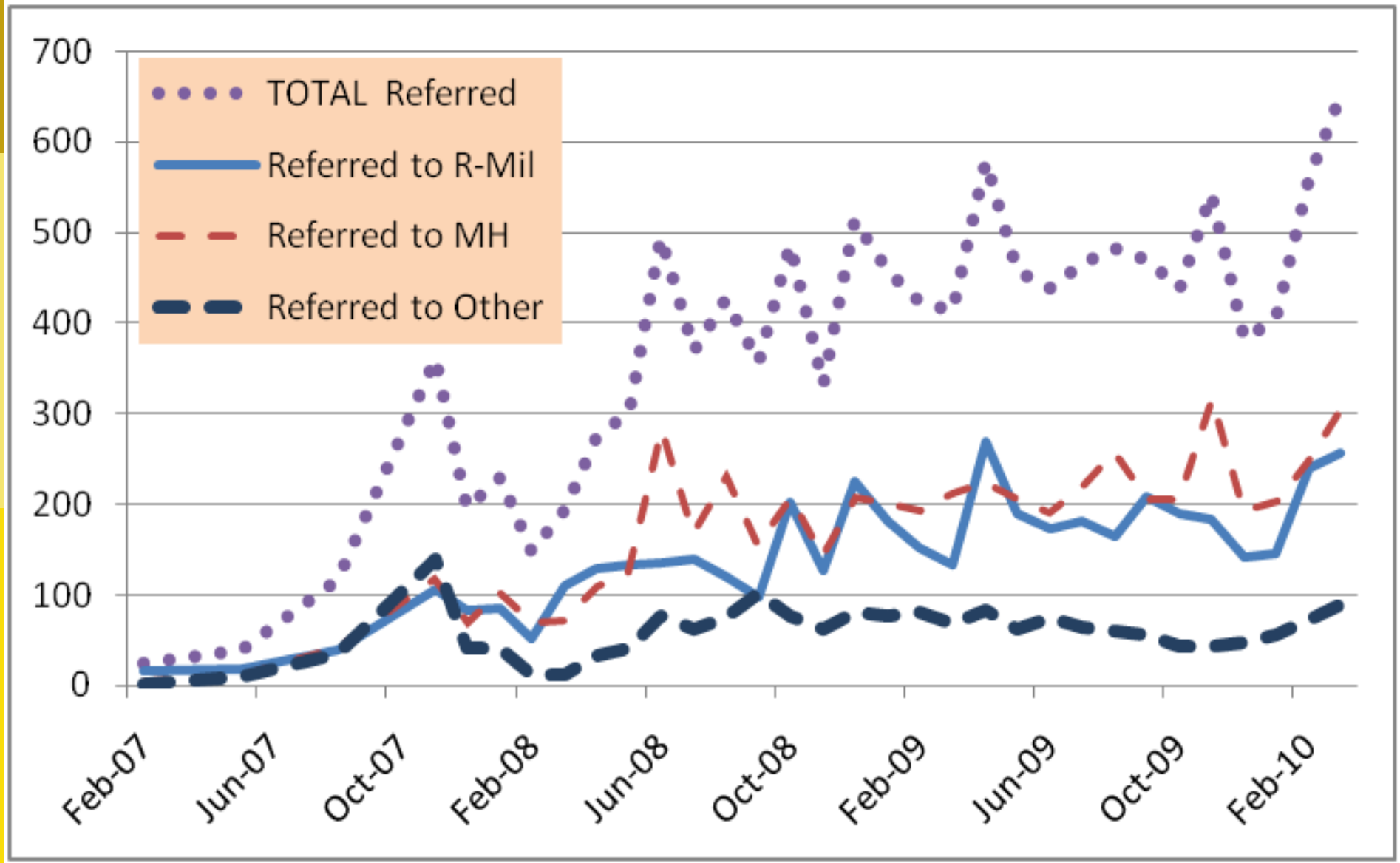
RESPECT-Mil Screening Visits

All Sites February 2007 to March 2010



Referrals for Enhanced BH Services

RESPECT-Mil Screened Visits, Feb '07 to Mar '10



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Implementation Results

- 35 clinics now implementing (of 42)
- 75% of visits screened (versus 2-5% in non-RESPECT-Mil teaching clinic)
- 12% of all screened visits are positive
- 39% of positive screens result in a diagnosis of ‘depression’ or ‘possible PTSD’

** Data through March 2010*

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Dispositions

66% assistance rate

accept/[accept + decline]

2.0% of all visits

involve recognition & assistance for previously unrecognized mental health needs

** Data through March 2010*

RESPECT–Mil

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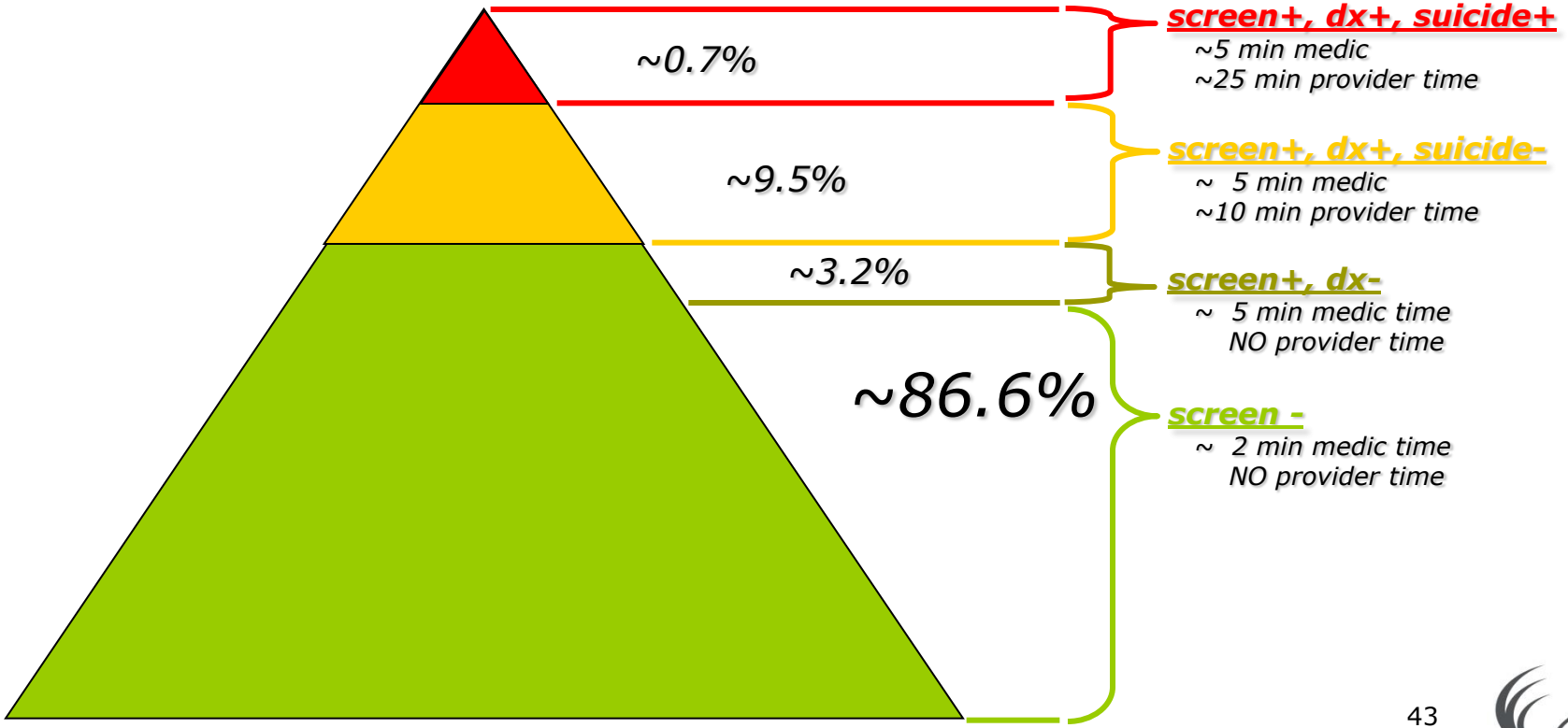
Creating Efficiencies

*~ **90%** of visits require **NO** added provider **time***

*~ **84%** of added clinician time is for the **0.7%** of visits at highest risk*



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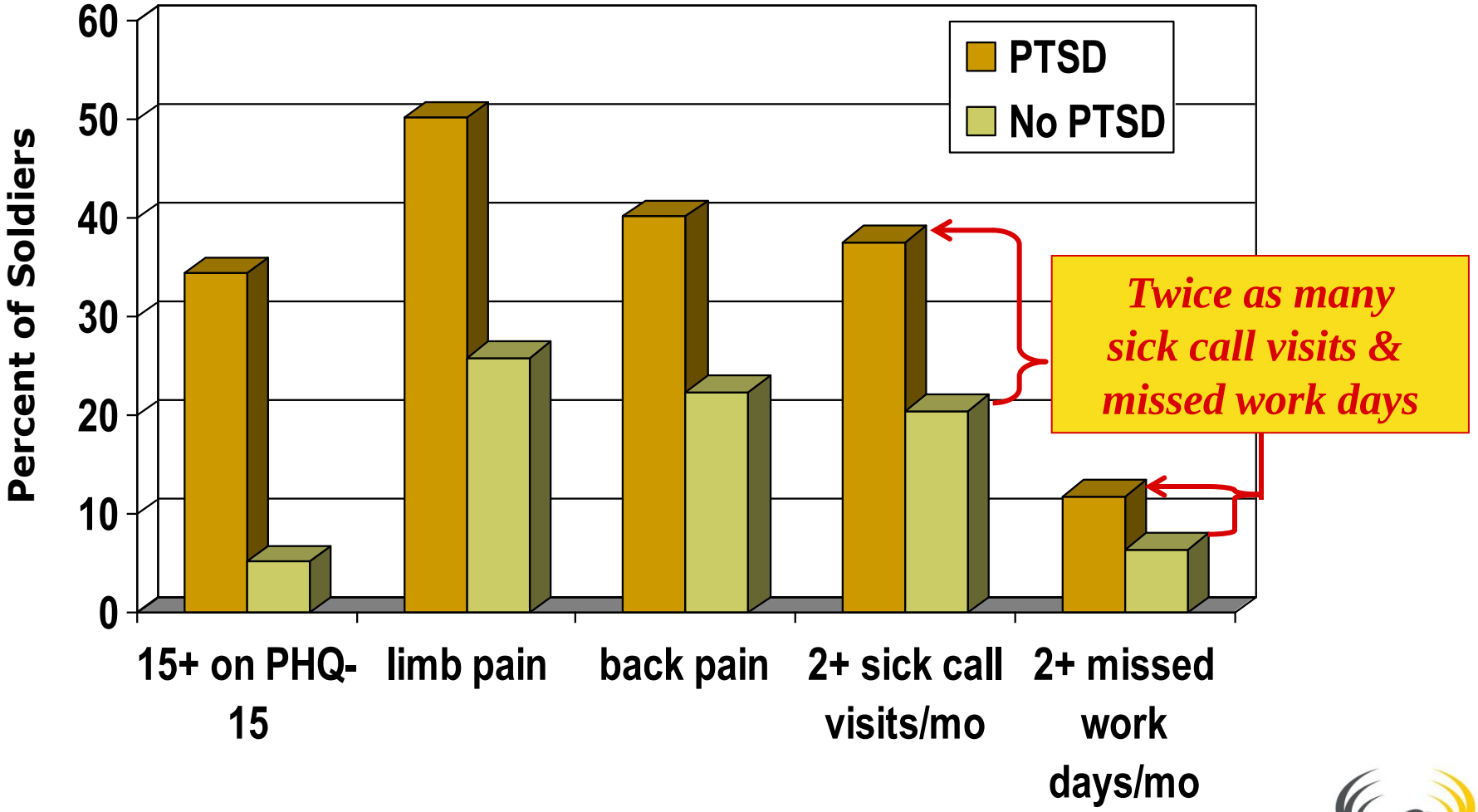
Potential for Offset: Service Use & Missed Work

2,863 Iraq War returnees one-year post-deployment



Hoge et al, Am J Psychiatr, 2007

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Safety & Risk Management

- ★513,446 visits screened*
- ★31,000+ visits screened/month & rising
- ★Ongoing risk event monitoring
- ★4,713 visits involving Soldier suicidality
- ★Frequent "save" anecdotes

** Data through March 2010*

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Safety & Risk Management

Visits associated with any suicidal ideation

- 1% of all visits (6.8% of screen positive visits)
- 23.9% of visits involving suicidal ideation are rated by provider as intermediate or high risk ("non-low risk")

** Data through March 2010*

Risk event monitoring -- suicidality

- Provider fails to assess risk in only 3.3/10,000 visits
- Provider rates as non-low risk & referral is declined in only 1.6/10,000 visits

** Data through March 2010*

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Findings to Date

- ★ Often concerns about getting started
- ★ Once started, approach is acceptable and feasible for both Soldiers and providers
- ★ Enrolled soldiers show clinical improvement
- ★ Identifying & referring Soldiers with previously unrecognized and unmet needs
- ★ Enhanced safety and risk assessment capabilities

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Challenges & Road Ahead

- ★ Provider training and retraining
- ★ Expansion site training
- ★ Web-based training ongoing
  http://www.pdhealth.mil/respect-mil.asp
- ★ FIRST-STEPS performance reporting
- ★ Developing triservice demonstration using blended approach
- ★ Intercalation with "Medical Home"
- ★ Five-year six site controlled trial of an enhanced RESPECT-Mil intervention in the IRB system

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Questions?

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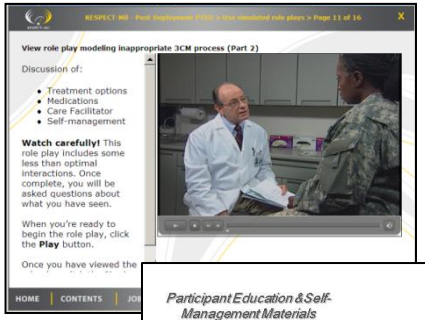
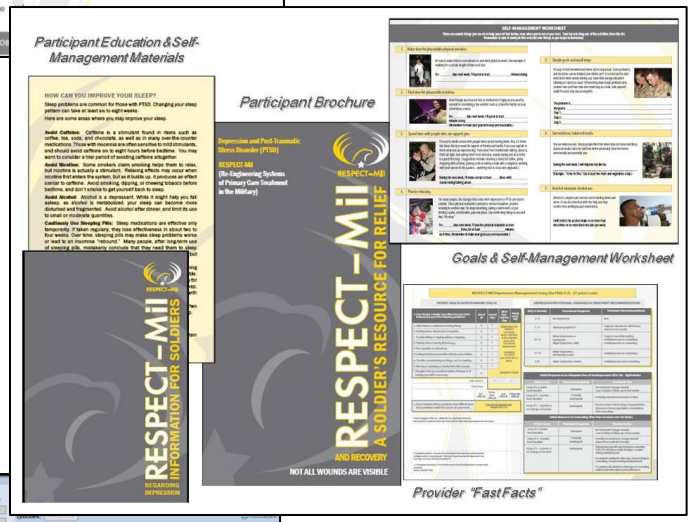
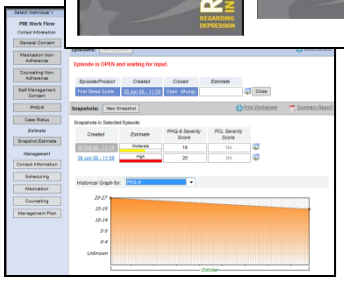
Evidence-based systems approach to primary care integration

- ★ Primary care program for PTSD & depression management
- ★ Uses '3 Component Model' (3CM®)
- ★ Nurse care management
- ★ Weekly psychiatrist oversight
- ★ Codified in hardcopy manuals
- ★ Web-based care management
- ★ Web-based provider training
- ★ Self-help literature adapted to military
- ★ Central implementation monitoring & routine suicide safety auditing
- ★ 42 clinics (7 overseas) expanding to 95
- ★ 482,205 active duty visits (suicidal ideas in 4,531)*



Provider Web Training





Web-Based Care Management Support & Benchmark Metric Reporting

* *Data through February 2010*

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DoD "STEPS-UP"

Stepped
Treatment
Enhanced
PTSD
Services

Using
Primary Care

A 6-site (18 clinic) RCT comparing 12-months of a system of collaborative PTSD and depression care versus usual primary care in the DoD health care system.

Supported by a DoD grant (DR080409) from the Congressionally-Directed Medical Research Program (CDMRP)

DHCC
DEPLOYMENT HEALTH CLINICAL CENTER

STEPS-UP Investigators

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***Initiating*: Charles Engel, MD MPH (USU / DHCC)**

***Partnering*: Robert Bray, PhD (RTI International)**

***Partnering*: Lisa Jaycox, PhD (RAND Corporation)**

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Brett Litz, PhD, MA (Boston Univ & VA)
Terri Tanielian, MA (RAND)
Christine Eibner, PhD (RAND)
Jürgen Unützer, MD, MPH (UW, Seattle)
Wayne Katon, MD (UW, Seattle)
Donald Brambilla, PhD (RTI)
Michael C. Freed, PhD (DHCC/USUHS)
Kristie L. Gore, PhD (DHCC/USUHS)
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Kris Peterson, MD (Ft Lewis, WA)
Melissa Molina, MD (Ft Bliss, TX)
Mark Reeves, MD (Ft Carson, CO)
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John Williams, MD (Duke & Durham VA)
Kurt Kroenke, MD (Regenstrief Institute)
Kathryn Magruder, PhD (MUSC)
Charles Hoge, MD (Walter Reed Army Institute of Research)

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Time & Workload

component	% visits	estimated time / visit
All clinic patients	100.0%	2 minutes medic time
Screen positive	13.4%	3 minutes medic time
Diagnosis	10.2%	10 minutes clinician time
Suicidality	0.7%	25 minutes clinician time

Total Estimated Time Per Visit

Medic = 2 + (0.134 x 3) = 2.4 min

Provider = (0.102 x 10) + (0.007 x 25) = 1.2 min

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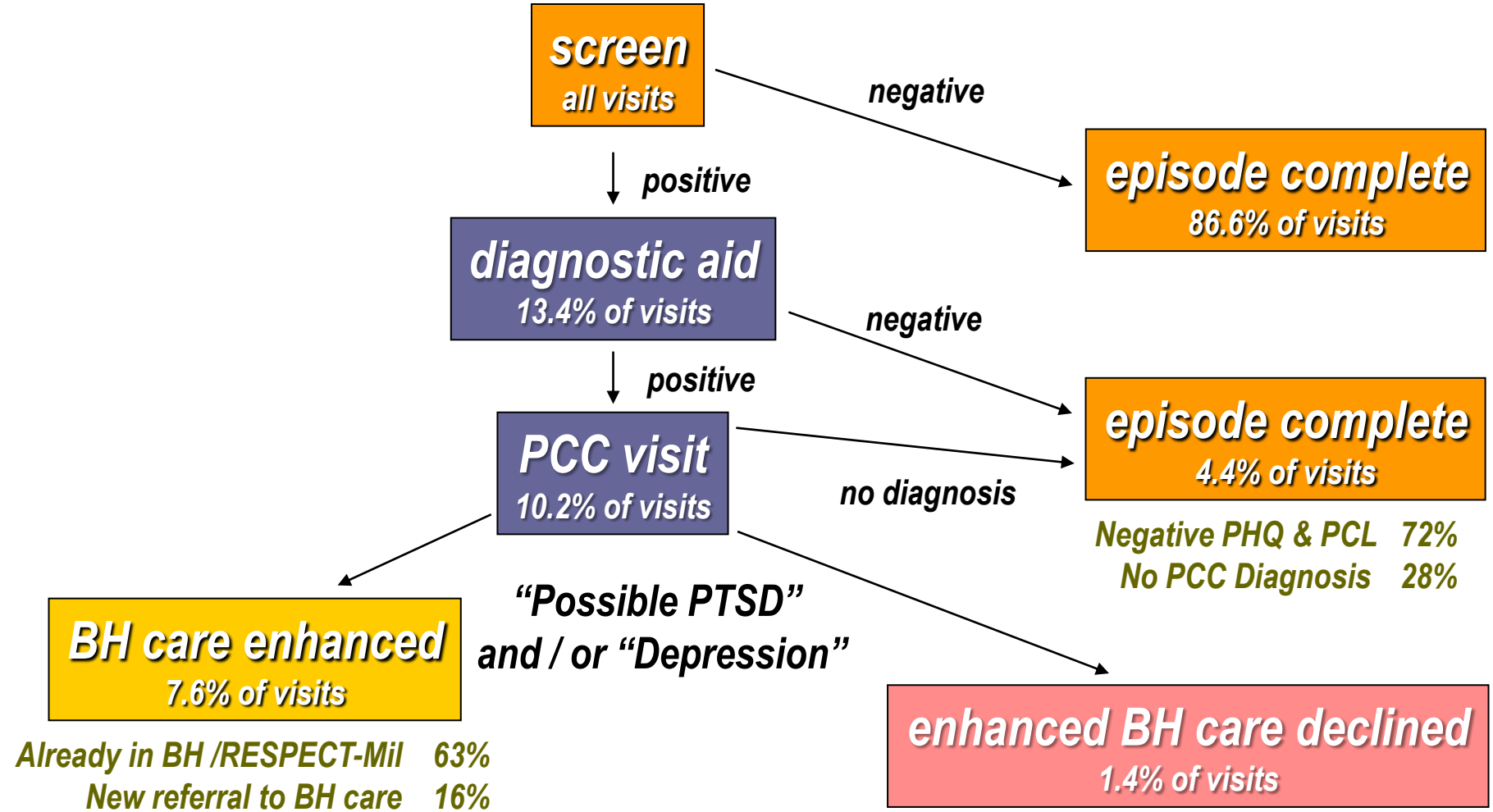
Patient Flow & Clinic Process



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